Bureau of Professional Licensing
PO Box 30670 ● Lansing, MI 48909
Telephone: (517) 241-0560
www.michigan.gov/bpl
BPLHelp@michigan.gov

CERTIFICATION OF POSTGRADUATE TRAINING

Authority: 1978 PA 368

This form must be submitted directly to this office by the director of medical education office. If this form is submitted by the applicant, it will not be accepted.

Section of Form to be Completed by Applicant:

Applicant's Name (First, Middle, Last)		Date of Birth
Address		
City	State	Zip Code
Telephone Number	Email Address	
Name of Medical School		
Applicant's Signature	Date	

Remainder of Form to be Completed by Director of Medical Education:

Name of Hospital or Institution		
Address of Hospital or Institution		
City	State	Zip Code

CERTIFICATION AND SIGNATURE

I certify the applicant named above has successfully completed postgraduate clinical training offered by the hospital or institution named above from

_____ to _____, in the clinical area of _____.
(Month/Day/Year) (Month/Day/Year)

This is an active program accredited by the ACGME, the Liaison Committee on Medical Education, the Joint Commission on Accreditation of Hospitals or the National Joint Committee on Accreditation of Preregistration Physician Training Programs of the Canadian Medical Association.

_____ _____
Signature of Director of Medical Education Date

_____
Print or Type Name of Director of Medical Education (Seal) If hospital has no seal, please indicate.

NOTE: Certification of Postgraduate Training will not be accepted if signed and submitted more than 15 days prior to actual completion.